

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-012707

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 275 Primary Registration District No. 3053 Registrar's No. 70

FILED MAR 20 1963

1. PLACE OF DEATH a. COUNTY Phelps		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Phelps	
b. CITY (If outside corporate limits, give TOWNSHIP only) Rolla		Length of stay in 1b 11 days	
c. FULL NAME OF (If NOT in hospital, give location) Phelps County Memorial Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) DANIEL JOSEPH HALEY		4. DATE OF DEATH Month March Day 12 , Year 1963	
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH 4-15-1894
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic retired		10b. KIND OF BUSINESS OR INDUSTRY Ford Motor Company	
11a. FATHER'S NAME Pete Haley		11b. MOTHER'S MAIDEN NAME Mynie Finn	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no none		16. SOCIAL SECURITY NO. [REDACTED]	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Generalized arteriosclerosis DUE TO (c) [REDACTED]		14. NAME OF HUSBAND OR WIFE Julia Haley	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) pulmonary emphysema		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. Month, Day, Year [REDACTED]		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION Blooming Rose, Mo.	
21. I attended the deceased from 3-2-63 to 3-11-63 and last saw him alive on 3-11-63 Death occurred at 1:15 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.		22c. DATE SIGNED 3-13-63	
22a. SIGNATURE Robert B. Young, M.D.		22b. ADDRESS 11th & Bishop, Rolla, Mo.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3-14-1963	23c. NAME OF CEMETERY OR CREMATORY O'Malley Cemetery	
24. FUNERAL DIRECTOR Carl J. Glenn		25. DATE RECD. BY LOCAL REG. Mar. 13, 1963	
26. REGISTRAR'S SIGNATURE Nadene L. Stoll		27. ADDRESS Blooming Rose, Mo.	

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MAR 26 1963

MAR 21 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

Carl J. Glenn

Licensed Embalmer No. 4707

P. O. Address Rolla, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.